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ABSTRACT

From the surge of recent litigation it appears that the civil rights movement has at last discovered another oppressed minority. Traditionally, society and the courts have ignored mental patients during their institutional confinement. Particular attention has been paid to the newly emerging concepts of rights to treatment, least restrictive alternative, and the right to refuse treatment. The recent concern about the abuse of behavior modification or applied behavior analysis, which is intended to strengthen adaptive behavior and weaken maladaptive behavior by properly structuring the patient's physical and social environment, is under close scrutiny from civil rights advocates and the judicial system. The purpose of this critical review is to survey some of the salient litigation related to the area of behavior change. Emphasis will be concerned with the involuntarily confined mentally deficient individuals. The review will cite and discuss some of the most recent landmark decisions in the judicial sphere, definitions of applied behavior analysis as they relate to a behavior change model, implications of legal decisions to applied behavior analysis and finally a stepwise flow chart indicating the most astute manner to program a behavior change. (Author)

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RECENT LITIGATION AND APPLIED BEHAVIOR ANALYSIS

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From the surge of recent litigation it appears that the civil rights movement has at last discovered another oppressed minority. Traditionally, society and the courts have ignored mental patients during their institutional confinement. Particular attention has been paid to the newly emerging concepts of rights to treatment, least restrictive alternative, and the right to refuse treatment. The recent concern about the abuse of behavior modification or applied behavior analysis, which is intended to strengthen adaptive behavior and weaken maladaptive behavior by properly structuring the patient's physical and social environment, is under close scrutiny from civil rights advocates and the judicial system.

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TABLE OF CONTENTS

Introduction and Recent Litigations 1

A. Right to Treatment 3
B. Least Restrictive Alternative 4
C. Consent 5
D. Liability 6

Behavior Modification 7

Implication for Applied Behavior Analysis 10

Table 18

Conclusions 19

Flow Chart for Involuntarily Confined Individuals 21

INTRODUCTION AND RECENT LITIGATIONS

The purpose of this review is to survey some of the salient litigations related to the area of behavior change techniques. Emphasis will focus on a brief historical survey of the landmark decisions in the judicial sphere, and questions and implications for applied behavior analysis.

In this past decade, the courts have focused on the area of treatment of involuntarily committed mentally deficient people. The decisions by the courts and accompanying ramifications will be the major issue addressed by this paper.

Litigation can be a valuable tool and catalyst in serving to heighten public awareness of "rights" of minorities. It also can serve as a guideline that holds administrators accountable to objective and enforceable norms. It should be emphasized, however, that litigation is not a panacea -- that courts have a difficult time in conceptualizing many technical programs and terminologies. Nonetheless, articulation of basic rights and interpretation will be discussed in the following paragraphs.

Mentally retarded individuals who are involuntarily committed to a state or private institution are especially susceptible to infringement of their rights. In its basic policy statement on the "Rights of Mentally Retarded Persons", October, 1973, the American Association on Mental Deficiency (AAMD) makes clear that a moral and ethical stance is necessary to protect mentally retarded individuals. "Professionals in the field, individually and in concert, should assert leadership in protection of these rights, in assuring their exercise and enjoyment by retarded citizens and in the implementation of

these rights to provide for more satisfying circumstances of life for retarded persons." (AAMD position papers 1975, p.24). One of the major difficulties facing the advancement of this statement has been the lack of a lucid guideline.

The legal institutions have recently awakened from a stalwart policy of "hands off" and have begun to probe into technical and complicated issues of behavior change. The resulting judicial decisions have profoundly affected the way behavior technicians implement behavior change strategies.

The courts realize now that the mentally retarded individual also has inalienable rights. Many of the "rights" are under the auspices of the due process clause in the United States Constitution. The due process clauses are found in both the Fifth and Fourteenth Amendments as a restraint upon the Federal and State governments. The clauses afford protection against arbitrary and unfair procedures in judicial or administrative proceedings which could affect the personal and property rights of a citizen. The due process clause of the Fifth and Fourteenth Amendments also provide other basic protections whereby the State and Federal governments are prevented from adopting arbitrary and unreasonable legislation or other measures which would violate individual rights (Subcommittee on Constitutuional Rights, 1975).

The element of due process began to curtail the wide discretion to which administrations had been accustomed. For example, it was now necessary to have specified in objective terms that behavior which would result in a reprimand. In addition, it is necessary to have a hearing before an impartial party allowing the individual opportunity to defend himself.

The second focal point of litigation has extended under the equal protection clause of the Constitution. Under this principle, certain rights and freedoms are deemed so basic to the people in a free and democratic society

that state government may not violate them even though they are not specifically banned from doing so by the Constitution. In addition, this requirement prevents the state from making unreasonable arbitrary distinctions between different persons as to their rights and privileges. In other words, one group of people cannot be treated differently from another group. This can restrict a behavioral technician that has singled out one group of individuals for a token economy system without being able to justify making the distinction.

The third and by far most extensive source of law is in the common law proceeding. Several recent cases (e.g., Wyatt vs. Stickney, Donaldson vs. O'Connor, Kaimowitz vs. Michigan) must be understood by those who are interested in applied behavior analysis (Murdock, 1972).

The Right to Treatment

The first truly significant judicial development in the area of right to treatment occured in Rouse vs. Cameron, 1966. Rouse was acquitted of a criminal charge by reason of insanity and was committed to a mental institution. He sought release from the institution on grounds that he was not receiving treatment. The Federal Appeals Court relied on a statutory right to treatment which was recognized by the District of Columbia Circuit by virtue of the 1964 Hospitalization of the Mentally Ill Act. The court specifically determined that the act did provide a right to treatment which could be judicially enforced.

Subsequent decisions have further defined the right to "least restrictive alternative". One example is Wyatt v. Stickney, 344 F. Supp 373, 344, F. Supp 387 (M.D. Ala, 1972) Aff'd sub nom, Wyatt v. Anderholt, 503 F. 2d. 1305 (5th Cir, 1974). The court focused on three fundamental conditions for effective and adequate treatment. These are constitutionally protected rights and not privileges. They must be provided. In the past, many of the management

techniques used in some institutions would rely on these rights as reward, and would be disseminated only upon the appropriate contingencies. Individuals have the right to; (1) a humane physical and psychological environment, (2) qualified staff in numbers sufficient to administer adequate treatment, and (3) individualized treatment plans. In addition, the court enumerated in great detail basic standards constitutionally guaranteed to hospitalized mental patients. Among these were the right to least restrictive conditions necessary for treatment, the right to be free from isolation (however courts do recognize legitimate timeout procedures), the right not to be subject to experimental research, and finally the right not to be subjected to behavior modification programs without prior certification by a physician in regard to any possible behavior that is caused by a physical condition which could be corrected by appropriate medical procedures. In addition, there is the right not to be subjected to behavior modification programs which serve only the institutional convenience.

Donaldson v. O'Connor established that in addition to minimum living conditions, there is a right to either treatment or release. The state mental hospital has a constitutional obligation to institute individual treatment plans as well as give the patient a reasonable opportunity to be cured or to improve his mental conditions (Martin, 1975).

Least Restrictive Alternatives

Least Restrictive Alternative method suggests that when a behavior change program is undertaken, the technicians must demonstrate that a less restrictive approach would not be worth pursuing. "The constitution requires that whenever a government is going to restrict a person's liberty against his will in order to accomplish a legitimate governmental objective, it must impose the least drastic restrictive necessary to accomplish the ligitimate governmental objective." (Mental Health Law Project, 1973).

Covington v. Harris states that the application of the litigation related to least restrictive alternative would not only support the constitutional right to citizens but also assures the release of inappropriately confined patients from hospitals, hence allowing treatment opportunities to those people who are in dire need of an institutional setting.

Consent

Common law - a body of legal principle based on precedents set by court decisions rather than on statues passed by legislation - protects every citizen of our fundamental right to informed consent. As established in the Fifth and Fourteenth Amendments for consent to be given to a particular treatment it must be competent, knowledgeable, and voluntary. The Kaimowitz v. Michigan Department of Mental Health court held that competency capacity to give requires the ability of the subject to be cognizent of the nature of the procedure, its benefit: risk ratio, and other relevent information. The second requirement is that the consent be knowledgeable. Problems of comprehension must be addressed and the amount of information given to the patient must include the necessary element to give a rational and informative decision.

Particularly interesting is the potentially coercive effect of closed institutions. The client should be able to decide voluntarily whether he/she wishes to undergo a particular treatment. It could be argued that informed consent is unobtainable in an institutional setting because release from the institution is sometimes so overpowering that any consent given must be deemed to be coerced.

Further, patients who have given intitial consent are permitted to withdraw consent and terminate procedures at will. While these free revocability principles may make sense in general, more discussion is in order concerning its applicability to behavior procedures (Wexler, 1975).

Liability

There has recently been a case where money has been awarded to a patient because of a failure to provide him with adequate treatment. In Donaldson v. O'Connor (Civ. Action No. 1693 C.N.D.A. Fla., decided Nov. 28, 1972), damages were assessed individually against the superintendent of Florida State Hospital and a staff of psychiatrists at that hospital and not against the state. The court stated that any person who is involuntarily committed to an institution has the right to receive treatment (Mental Health Law Project, 1973).

In conclusion, common law judicial decisions have held that constitutionally guaranteed rights to due process and equal protection as well as the First and Eighth Amendment rights do apply to involuntary mental deficient populations. Basically, a behavior change program must meet certain minimum standards of care. The individual must be treated under an individual planned program, all programs must be reviewed periodically, coercion must not be allowed in obtaining informed consent, the least restrictive treatment alternative is to be explored and, finally, a person in charge of the behavior change program can be held personally liable.

BEHAVIOR MODIFICATION

The area of behavior change and its techniques are comparatively new. There are problems with precise definitions of terms. For example, the term "behavior modification" is most familiar and generally descriptive. Behavior modification is itself the source of substantial controversy. Major court decisions have utilized the global definition of behavior modification: a specialized type of behavior therapy utilizing physical punishment, electroconvulsive therapy, genetic manipulation, psychopharmocology, and psychosurgery.

The Department of Health, Education, and Welfare used the following definition of behavior modification: "The systematic application of psychological and social principles to bring about desired changes in or to prevent development of certain problematic behavior and responses." To further confuse the definition, the Senate Subcommittee on Constitutional Rights, 1974, mentions that common elements of behavior modification programs utilize methods of direct and systematic manipulation of "personality" through the use of applied psychological, medical, and other technological methods. Behavior modification is not a learning phenomena because there is not exchange of information. The above material is not only confusing but also misleading. Terms such as "manipulating personality," and "exchange of information" are completely alien to the science of behavior change. Others who are more closely aligned with the science, argue that any learned response to a stimulus utilizing objective and observable definitions such as emperical observations; defining terminal behavior; breaking terminal behavior down into small sequential steps; modeling or prompting each step; rehearsing the newly acquired behavior; reinforcing successful performances; and arranging contingencies in the natural environment to maintain responses, is a more objective definition of the science called Applied Behavior Analysis.

When Friedman, (1975) defined Applied Behavior Analysis he referred only to the end product of the treatment--a change in behavior. An Applied Behavior Analyst is a person who studies clinical phenomena through operationally-defined and experimentally-manipulated variables; emphasizes the effect of stimulation in directing individual behavior; and approaches inappropriate behavior bhrough a learning theory paradigm rather than a medical model framework. In addition, he utilizes the use of extrinsic reinforcement as a meaningful way of altering behavior or maintaining one's behavior.

Many misconceptions arise from the definitions of Applied Behavior Analysis and Behavior Modification. For example, it is difficult to understand what is meant by the term Applied Behavior Analysis. It refers to only one of the three major branches of behavior change techniques. The three branches evolved from experimental procedural differences which led to different explanations of learning and behavior.

The first of these techniques is derived from the early writing and experimentation of Pavlov and extended by Hull. The classical conditioning phenomena which lay persons equate with behaviorism or Applied Behavior Analysis. In classical conditioning an antecedent stimulus elicits and demands a response. After repeated pairing of a neutral stimulus to the unconditioned stimulus that elicits an unconditioned response (reflex), the neutral stimulus takes upon itself many of the unconditioned stimulus properties. A variety of behavior change techniques including systematic desensitization (Wolpe, 1970) and aversive conditioning (Bandura, 1969) are based in this conditioning principle.

The second technique of benavior change is the utilization of mediation between stimuli and behavior. Consequences of a behavior or preceding stimuli are not necessary for behavior change to occur. A person may respond after

observation or demonstration of a behavior. Mediation theory is also distinguished from acquisition of a behavior and performance (Bandura, 1965).

The term Applied Behavior Analysis should only apply to this third technique called instrumental or operant. The antecedent stimulus controls behavior only because of the consequence of that behavior. For example, a child that receives verbal praise for helping clean the day room and if the helping behavior increases in frequency, then the Applied Behavior Analyst can state that the frequency of helping behavior could be related to the consequence of the behavior itself (Goldiamond, 1975).

To someone not professionally familiar with the systems involved, many of the procedures of one are indistinguishable from one another. For example, both aversive conditioning and aversive control procedures utilize an aversive event pair with a specific response. However, an Applied Analyst realizes that aversive conditioning is the program that is set up by the investigator. He arranges the pairings at his convenience. In addition, aversive conditioning is used to decreasc behavior. On the other hand, aversive control would involve either an increase or decrease in behavior. The intent is not to trap the individual into a specific milieu and tnen apply shock contingent upon a response, but rather apply the consequence immediately when the behavior occurs at its operant level.

Applied Behavior Analysis should be discussed as a technique of global behavior change, but it should be restricted to its' rationales and procedures and to that part of a judicial or legislative decisions attributable to their use and not to other behavior modification techniques in general, e.g., psychosurgery, gestalt therapy, psychotherapeutic therapy, systematic desensitization etc. Precise definitions are necessary to resolve confusion surrounding behavior change techniques and conceptualize behavior schemes that may attribute to future judicial and legislative enactments (Goldiamond, 1975).

IMPLICATION FOR APPLIED BEHAVIOR ANALYSIS

Due to the recent litigation and legislation a number of concerns may arise with regard to involuntary confined mental individuals. One area a therapist needs to be consistent in is informing every individual as to what they are consenting to. The informing process must be in the client's native language. All information should be at an appropriate comprehension level. The subject should be able to discuss the information to an informed group of impartial people. This fundamental right, afforded under the United States Constitution however, requires that any person who has the capacity to give informed consent and who refuses certain behavioral procedures, may not be compelled to undergo such procedures. Furthermore, the court decided in Kaimowitz v. Michigan that an involuntarily confined mental patient could not truly volunteer since the conditions of confinement are inherently coercive.

> "There is no true choice between programs. Program enrollments and progress are maintained through coercion. That is, for a program to be fully noncoercive within the confines of an institution which is inherently coercive, program participation or nonparticipation must be divorced from the different consequences society, through its authorized institutional agents, couples with socially desireable or undesireable behavior. In most cases those consequences are freedom or incarceration" (Goldiamond, 1975, pp. 124-125).

The court needs to define the parameters of the Kamowitz decision in terms of the right to treatment and the conditions of consent. Changing individual behavior to prompt environmental adjustment is legitimate and ethical (e.g., to teach a hyperactive mentally deficient child to remain seated to establish the control that will allow continuance of on-task behavior). Whereas changing behavior to accomodate the institution and staff is regarded as unethical. The area of confusion for the Applied Behavior Analysis program is that it is

the same program. The ethical and moral nature of the program must be defined. The basic problem in the behavior change area occurs when a suggestion of consequence enters into the selection of a treatment program.

The next area of concern to the ABA is related to the adoption of generally accepted treatment or experimental treatment. The former technique utilizes common psychological interventions, e.g., positive social reinforcers, extinction, and Differential Reinforcement of Other Behavior (DRO). Certain other techniques which may be proposed for management of behavior are classified experimental if there has not been enough testing to assure a negligible risk involvement. In other words, if there is limited supportive data to insure efficiently in the technique, it would be classified as experimental. These techniques are to be used only when they are judged to be in the best interest of the individual. When a therapist desires to use an experimental treatment approach, it is necessary to submit a copy of the treatment to a board of qualified researchers to evaluate the scientific merits of the proposal and the validity of the research design before implementation of the program. Examples of experiment technique are electrical stimulation of the brain, experimental drugs, and forms of biofeedback.

Martin (1975) mentions that in determining if the strategy of intervention is classified as experimental in design or novel in technique, "one" should be aware of the following:

> "Your clients should be volunteers, you must be able to clearly detail risks and benefits, (the benefit: risk ratio must be substantial), there must be a general public interest in undertaking the experiment, the information should not be obtained in any other way, and the results must be carefully gathered through a well planned research design." (pg. 38).

These statements may rebound against the development of foreseeable "least restrictive" behavior change technique and upon the fundamental philosophy of a humanistic society. Advances in research are especially dependent on advances

in treatment. Curtailment of research treatment must hinder advances in understanding and improving patient care. The stagnation of intellectual flow will undoubtedly threaten the emergence of new and superior standards of treatment in the applied setting. For example, when a proposal is presented to the Human Rights Committee and Peer Review Committee, the first question that needs to be an wered is whether there is supportive data in the literature that would give evidence to the effectiveness of the procedure (Goldiamond, 1975). Ten years ago, many of the acceptable techniques were not available to the ABA. The proposal to implement the new procedures would be denied because of the lack of supportive data in the professional literature.

Consider the following dilemma. There is a risk-benefit ratio involved even in acceptable or traditional practices. An experimental procedure must have many more safeguards such as obtaining consent and review committees etc. There must also be clear explanations of the risk and possible benefits and there must be some public good to be gained from engaging in the experiment. No approach is guaranteed to bring a benefit and any approach can go wrong and entail some risk. But, if it can be demonstrated through professional literature and widespread practice that the benefit consistently outweighs a risk which is negligible, then and only then would it be considered an acceptable approach. In an experiment approach, there has not been enough testing to assure that the risk is negligible or that the benefit will outweigh it. Furthermore, consent should be obtained for each discrete step in the process, pre-program, baseline data, information gathered during, evaluation follow-up, publication. A person consenting to participate in a program of treatment is not necessarily consenting to the eventual publication of the results.

The problem has arisen that there has not been enough testing with new techniques to assure an approximate risk:benefit ratio. "This does not mean you cannot

deviate from traditional practice, attempt to find something better, or even conduct research on your effort, so long as you assure there is not a large risk involved" (Martin, 1975). How can an objective behavioral scientist realize a benefit-risk ratio without scientific experimentation? Another concern with the definition of an experimental procedure is examplified in this statement, ". . . There must be a general public interest in undertaking the experiment" (Martin, 1975; pg. 38). Little data of scientific merit would be produced if it were necessary to have the public responsible for activating interest in a scientific undertaking. Thus, the problem arises when searching for procedures to facilitate the least restrictive alternative requirements are thawarted by the demands for supportive data on the risk:benefit ratio in a experimental approach.

A third concern would be the duration of a program. Is it "least restrictive" to use an aversive contingent treatment program over a brief period or a less restrictive program that may linger for months? Is the less restrictive confinement with a less effective treatment program more or less restrictive than an aversive treatment program that lasts a few moments?

It has been discussed that it is not constitutionally permissable to utilize certain items, activities, and events as reinforcers in a behavior change program. There are some rights so basic that it would jeopardize a legal embattlement if they were employed on a contingent schema. When absolute rights are broadly defined, it infringes on the need for contingent rights which are essential to effective behavior change models.

Forth, many opponents of behavior modification or operant conditioning stated that deprivation and/or punishment could well reduce individuals to a subhuman level. How can we justify the use of operant conditioning in the name of reshaping a patient's behavior (Lucero, Vail & Scherder, 1970). In addition,

the opponents state that deprivation and punishment are never to be used and that positive reinforcement is the only conditioning technique to be used. The effectiveness of punishment and deprivation principles depends on many variables, and many parameters that are largely unknown to the scientific community. If nondeprivation contingencies could be developed that could motivate an unresponsive catatonic, then positive reinforcement alone would be sufficient. However, research evidence indicate that positive reinforcement works best with deprived subjects (Timberlack & Allison, 1974). To conform to the right to treatment in the least restrictive method, it seems necessary for some form of deprivation to occur. Any restriction of treatment in the most efficient and expedient manner would indeed be unethical and inhumane. Objections should be directed not towards the deprivation itself, but to the degree of sophistication with which it is employed.

Consider, for example, the maladaptive shaping of behavior that may occur in our institutions. A well-meaning attendant rushes over each time a child hits his head on the table and attends to this inappropriate behavior. She is unwittingly but systematically using the principle of operant conditioning to shape injurious behavior. Rather than prescribing techniques because of our unreasonable fear and misunderstanding, we should learn what is really involved in behavior change (operant conditioning).

The behavior appraoch, unlike many traditional "helping professions", utilizes objective definitions, examines the individual's unique behavior in relation to immediate social environment, explicits procedure, and tailors treatment to the individual and evaluation-criteria-based idiosyncratic characteristics. Finally, continual evaluation procedures are scrutinized and restructured to meet the above mentioned qualification. Thus, the behaviorist system is a programmed system and self-evaluative. It is more pragmatic and

explicit than any other therapeutic approach. The use of the explicit approach could provide incentive for comparative risk-benefit analysis with other techniques of theory. What decisions were made concerning the therapy of an individual will be based solely on the explicitness of the data. It seems ironic that legislation wishes to regulate the only therapy technique that is a system of self-regulation.

The fifth concern is directed toward the right to treatment requirement. An individual has the right to refuse treatment when offered. That is, all persons involuntarily confined to mental institutions have a fundamental right to refuse treatment which intrude upon the first, fifth and fourteenth amendment rights under the United State Constitution. The implications of this right may allow the confined individual the opportunity to set the occasions for a later law suit. The individual may sue the State and/or the professional staff at the institution. Mr. Donaldson, who was civilly committed to a Florida mental institution, refused treatment for 15 years. In 1974, Mr. Donaldson sued for his release claiming he had the right either to be treated or released. The Federal Court of Appeals for the Fifth Circuit held that there is a constitutional right for individuals to receive treatment that will help him to improve his mental condition.

The right to treatment does possess potential concerns. The right could be used to justify unnecessary increases in maintenance allotment from the respective state legislatures. In addition, it could also be used by the confined individual to justify the right to refuse adequate treatment when offered, thus allowing the agent to set the occasion for a later law suit. To date, the courts have not been very responsive to these concepts. Wyatt (1974) implies these procedures should be closely hedged with legal safeguards.

The use of sophisticated techniques in the management of behavior has come under close scrutiny of the judicial and public eye. However, there is a large area of behavior changesthat the courts have only begun, primarily, to investigate. The law has recently set the foundations for inquiry into the inalienable rights of children. Some behavior change techniques that are utilized under supervised direction are standard techniques in child rearing practices, i.e., sending a child to bed without his meal is technically a Type II punishment (withdrawal of reinforcement) and deprivation contingent upon an inappropriate behavior. In addition, a child may have the opportunity to earn some money upn completion of a specific behavior (token economy). This author suspects the courts will further address the ethical standards of conduct of parental obligation.

Involuntarily confined individuals in a mental institution are especially vulnerable to infringement of basic constitutional rights. Professionals and lay persons should assert leadership in protection of these rights, and in the implementation of these rights to provide for more satisfying circumstances of life for retarded persons (AAMD position papers, 1975).

When conceptualizing the treatment plan for a mentally retarded individual with regard to a behavior problem, every technician should be cognizant of the client's basic constitutional rights. Mentally retarded individuals should not be deprived of the "right to treatment" (Wyatt, 1974). Practitioners must take into account the vulnerability of this population when planning and implementing any part of an "individual treatment plan" (Wyatt, 1974).

In order to secure a technical legal position, the following steps are advised:

1. A professional review board should determine the validity of the procedures,
2. A human rights committee review the ethical and legal implications,

3. An experimental research review committee should review the merits and the validity of the research procedures (qualified research scientists),

4. Active participation by the client in selecting a program is advised, with appropriate consultation from guardian or legal representatives. Consent should be based upon competence, knowledge, and volition. In addition, the individual should be permitted to withdraw consent at any state of the program. Consent must also follow each phase of the program, i.e., baseline, treatment, follow-up, and possible publications.

5. A periodic reassessment of an individual treatment plan is advised. The treatment should be tailored to the individual in the least restrictive manner. Rehabilitation must occur under the treatment techniques. On-going clinical documentation is a major source of evaluation.

6. Behavior change for convenience of the institution and staff is not acceptable under the recent litigation.

7. Qualified supervision of each program is the constitutional right of each individual in a closed institution. In addition, standards must be maintained under the Wyatt decisions of 1974.

TABLE

Paraphrased version of some of the rights specified:

1. Privacy and dignity
2. Least restrictive conditions
3. Free from physical restraint and isolation
4. No experimental research without express and informed consent by patient or guardian or next of kin after consultation with legal counsel
5. No unusual treatment
6. Wear own clothes and personal possessions
7. Not to require labor
8. Right to minimum daily dietary allowance
9. Upon admission, notice of all standards for treatment

CONCLUSIONS

Although there are admissable principles of conduct recognized by the masses of Applied Bahvior Analysts, there is appraently no recognized code of echics for the field of Applied Beahvior Analysis. A code must be developed:

1. to regulate action if only because failure to do so will result in some appointed group of individuals developing the code; that resultant code could contain many of the ambiguities and panacea statements that we have already addressed.

2. to provide the technician with specific guidelines that would favor an ethical defense argument that would disuade an agent from formulating a malpractice suit against an Applied Behavior Analyst (Brian, 1975).

The serious Applied Behavior Analyst must demonstrate lasting stimulus and response generalization behavior change treatments in the institutionalized population. And lastly, lawyers must learn to see "behaviorists as other than sadists with cattle prods" (Stepleton, 1975, p. 41). There is a remote possibility that the explicitness of the behaviorist's philosophy could be used to clear the rheturic from the legal schemes, i.e., "indeterminate confinement" with built in "arbitrariness those criteria lack instructions, cues and prompts deemed by some Applied Behavior Analyst to be essential to effective contingency management programs" (Wexler, 1975, p. 173). The law is in need for contingencies, objectives and analyses. An Applied Behavior Analyst can play a role examining the legal system, impacting behavior principles, formulating explicity designs, suggesting alternative strategies, designing self-evaluation systems and lastly contribute "greatly to the law by seeking to define in behavioral terms certain crucial and troubling legal concepts" (Wexler, 1974, p. 174).

It may be possible that Applied Behavior Analysis and the law can function smoothly. Many aspects of behavior change technique are in dire need of

guidelines while many recent litigations are in need of "behavior jurisprudence." Research and communication in the areas are important to prevent stagnation and thwart mutual understanding.

FLOW CHART FOR INVOLUNTARILY CONFINED INDIVIDUALS

In order to accomplish a behavioral change without fear of retribution, safeguards have been established. The following is a composite of procedure that a therapist could take to safeguard his behavioral change technique.

1.0 Formulation of a program. The therapist will complete an extensive information review as well as on-site analysis associated with an individualized treatment plan.

1.1 Obtain consent then collect background information on the client; the therapist will acquire information associated with client, e.g., what are his or her habits, what does he or she like, etc.

1.2 Objective behavior definition; identify target behavior and define in measurable units.

1.3 Analyze the need and ability for a behavior change; is the behavior change in the best interest of the client? Is it feasible to change the behavior under question?

1.4 Sequence levels of behavior to be learned; after identification of behavior, break the behavior into sequential objectives.

1.5 Specify terminal behavior of each sequenced level; after breaking the behavior down into sequential levels identify terminal criteria for each step.

1.6 Analysis treatment environment; on-site visit are necessary to identify possible contingencies.

1.6.1 If there are procedural errors in the program already implemented, revisions would be appropriate at this point. (consult 2.0)

1.7 Identify antecedent stimulus maintenance event; isolate if possible the stimulus which sets the occasion for the behavior under question.

1.8 Select contingencies; identify potential reforcing and/or punishing consequences.

1.9 Utilize research data; employ a design and procedure that can demonstrate procedural effectiveness.

1.10 Utilize staff imput; employ suggestions and procedural strategies that may contribute between staff communications.

1.11 Formulate intervention program; write program implementing previous research, staff contributions and client observation into a comprehensive objective manner.

1.12 Corrections and revisions; check for sentence construction and produce errors, revise as necessary.

2.0 Review Procedures.

2.1 Program submitted to professional review board; the procedures and designs need to be reviewed by a body of established professionals in the area of applied behavior analysis.

2.1.1 After review and if revisions are necessary, go to corrections and revisions (1.12)

2.2 Program submitted to human rights committee; the procedures, designs, and ethical consideration are reviewed by a body of individuals advocating the basic right of a client.

2.2.1 After review and if revisions are necessary, to to corrections and revisions 1.12.

2.3 Is the program an experimental approach?; the therapist needs to identify if the procedure is experimental by reviewing the literature. If there are any questions as to the approach, send a copy to the research review committee.

2.3.1 Research review committee; a body of experts in the field of Applied Behavioral Analysis reviews the proposal to determine the expected outcome and authenticity of the designs.

2.4 Client for review; the client, if possible, should review the program and contingencies (he has the right to refuse treatment).

2.4.1 After review and if revisions are necessary, go to corrections and revisions 1.12.

2.5 Consent; it is necessary to obtain consent for each phase of the program, e.g., baseline, treatment, written results, submission for publication.

2.6 "On hands" staff for review; the program should be critiqued by the staff member who has direct contact with the client.

2.6.1 After critiquing and if revisions are necessary, go to correction and revisions 1.12, or utilize staff imput 1.10.

3.0 Program implementation.

3.1 Baseline - gather baseline as quickly and efficiently as possible.

3.2 Implement treatment and gather data. The implementation and data gathering procedure are the most important stage.

3.3 Access program periodically. The law requires at least yearly. However, if data is collected correctly, adjustments and assessment could be made daily.

3.4 Terminal behavior obtained; from 1.5 terminal behavior identifed by objective definition.

3.5 Fading Procedures; to maintain response with less direct contingency manipulation a fading out procedure could be used.

3.6 Monitor; following data could be gathered to ascertain the effects of the program over time.

4.0 Terminal Goal

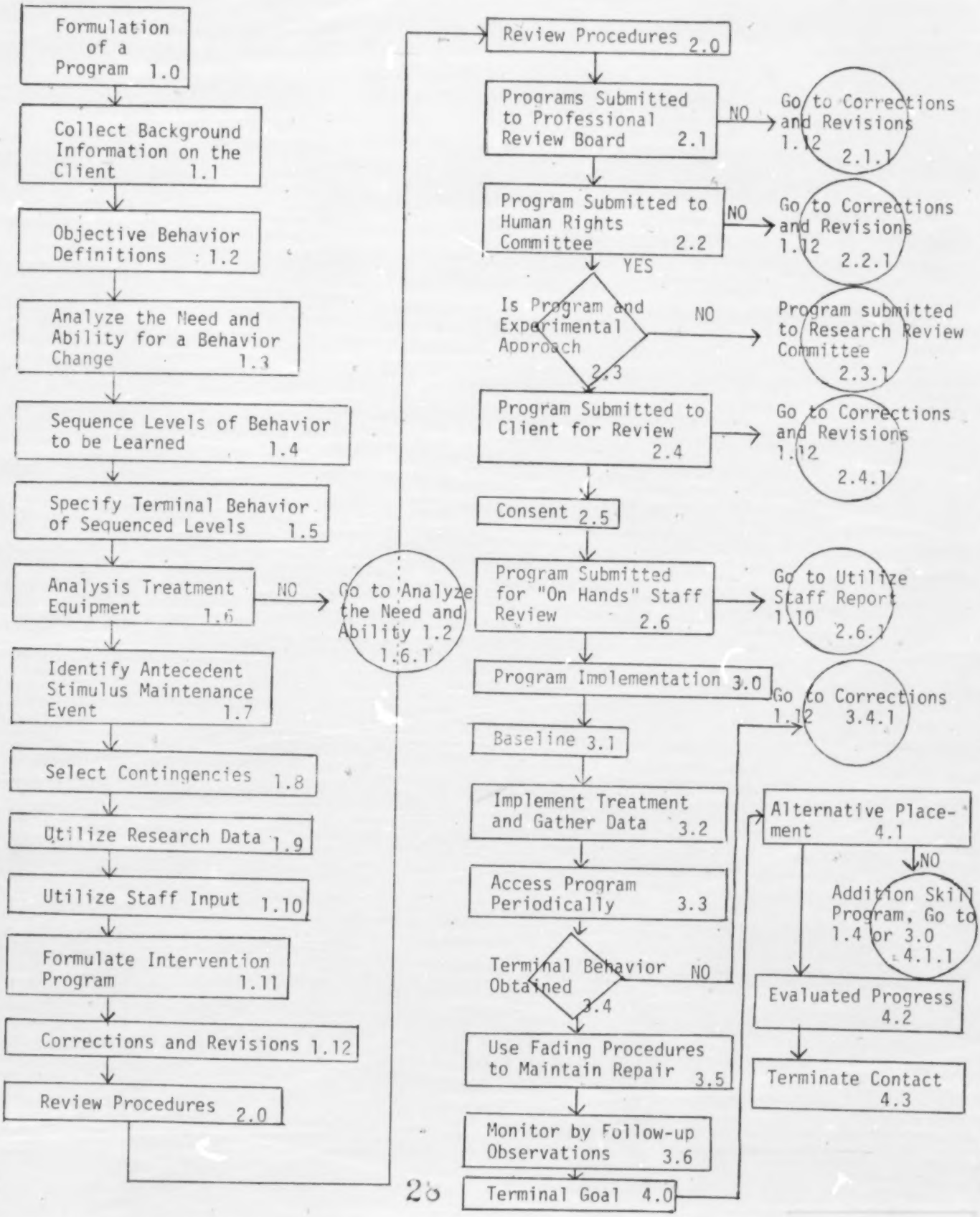
4.1 Alternative placement; employing the least restrictive environment philosphy evaluation of the clients progress could afford him or her a less restrictive placement.

4.1.1 Addition skill program; after evaluation of the terminal behavior addition skill may be necessary before alternative placement, go to sequence levels of behavior to be learned 1.4 or program implementation 3.0.

4.2 Evaluated progress; strutinize clients behavior while in the alternative placement periodically.

4.3 Terminate contact; the final goal of most all clients is the freedom of involuntarily confinement.

FLOW CHART FOR INVOLUNTARILY CONFINED INDIVIDUALS


Formulation of a Program 1.0
Collect Background Information on the Client 1.1
Objective Behavior Definitions 1.2
Analyze the Need and Ability for a Behavior Change 1.3
Sequence Levels of Behavior to be Learned 1.4
Specify Terminal Behavior of Sequenced Levels 1.5
Analysis Treatment Equipment 1.6
NO
Go to Analyze the Need and Ability 1.2 1.6.1
Identify Antecedent Stimulus Maintenance Event 1.7
Select Contingencies 1.8
Utilize Research Data 1.9
Utilize Staff Input 1.10
Formulate Intervention Program 1.11
Corrections and Revisions 1.12
Review Procedures 2.0
Review Procedures 2.0
Programs Submitted to Professional Review Board 2.1
NO
Go to Corrections and Revisions 1.12 2.1.1
Program Submitted to Human Rights Committee 2.2
NO
Go to Corrections and Revisions 1.12 2.2.1
YES
Is Program and Experimental Approach 2.3
NO
Program submitted to Research Review Committee 2.3.1
Program Submitted to Client for Review 2.4
Go to Corrections and Revisions 1.12 2.4.1
Consent 2.5
Program Submitted for "On Hands" Staff Review 2.6
Go to Utilize Staff Report 1.10 2.6.1
Program Implementation 3.0
Go to Corrections 1.12 3.4.1
Baseline 3.1
Implement Treatment and Gather Data 3.2
Access Program Periodically 3.3
Terminal Behavior Obtained 3.4
NO
Use Fading Procedures to Maintain Repair 3.5
Monitor by Follow-up Observations 3.6
Terminal Goal 4.0
Alternative Placement 4.1
NO
Addition Skill Program, Go to 1.4 or 3.0 4.1.1
Evaluated Progress 4.2
Terminate Contact 4.3

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